DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-006

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ -3,472,975
b. FFY 2005 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Att. 4.19A, pages:6, 8, 10-14, 20-22

Att. 4.19B, pages 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Att. 4.19A, pages:6, 8, 10-14, 20-22

Att. 4.19B, pages 1-3

10. SUBJECT OF AMENDMENT:
Chiropractic, orthodontic, frames/lenses, and dental services

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Governor has waived review

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Administrator

15. DATE SUBMITTED:
June 13, 2003

16. RETURN TO:

Margaret Booth
HHS-F&S
301 Centennial Mall South
Lincoln, Nebraska 68509

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 13 2003

18. DATE APPROVED: DEC - 1 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brown for Smith

21. TYPED NAME: Charlene Brown

22. TITLE: Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Peer Group: A grouping of hospitals or distinct part units with similar characteristics for the purpose of determining payment amounts. Hospitals are classified into one of six peer groups:

1. Metro Acute Care Hospitals: Hospitals located in Metropolitan Statistical Area (MSAs) as designated by Medicare.
2. Other Urban Acute Care Hospitals: Hospitals that have been redesignated to an MSA by Medicare for Federal Fiscal Year 1995 or 1996 and/or hospitals designated by Medicare as Regional Rural Referral Centers;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations;
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which they are located and distinct parts as defined in these regulations; and
6. Critical Access Hospital: Hospitals that are certified as critical access hospitals by Medicare.

Peer Group Base Payment Amount: A base payment per discharge or per diem amount used to calculate the operating cost payment amount. The peer group base payment amount is the same for all hospitals in a peer group except Peer Group 6.

Reporting Period: Same reporting period as that used for its Medicare cost report.

Subspecialty Care Unit: Provision of comprehensive maternal and neonatal care services for both admitted and transferred mothers and neonates of all risk categories, including basic and specialty care services; provision of research and educational support; analysis and evaluation of regional data, including those on complications; and initial evaluation of new high-risk technologies.

10-010.03B2 Calculation of Nebraska-Specific DRG Relative Weights and Case-Mix Index: Relative weights calculated for the rate period ending June 30, 2001, shall remain in effect. For payment purposes, relative weights are calculated using all applicable discharges for a single year for a period from January 1, through December 31, for the calendar year ending 2 years prior to the effective date of the recalibration. Statistical outliers which exceeded the average mean charges value by three standard deviations are excluded from the calculations.

Nebraska-specific weights are calculated from Medicaid charge data using the following calculations:

1. Determine the Medicaid charges for each discharge;
2. Remove all psychiatric, rehabilitation; Medicaid Capitated Plans, and Critical Access Hospital discharges;
3. Determine the arithmetic mean Medicaid charges per discharge for each DRG by dividing the sum of all Medicaid charges for each DRG by the number of discharges;
4. Determine the statewide arithmetic mean Medicaid charges per discharge by dividing the sum of all charges for all relevant discharges in the State by the number of discharges;
5. For DRGs with 10 or more cases, divide the DRG arithmetic mean charges per discharge for each DRG by the statewide arithmetic mean charges per discharge to determine the Nebraska-specific relative weight for each DRG;
6. For DRGs with less than 10 cases, relative weights will be borrowed from the Medicare relative weights that were effective for the Medicare program on October 1 of the preceding year.
7. Adjust the relative weights so that the average of all discharges equals 1.0.

10-010.03B2a Recalibrating Relative Weights: Relative weights calculated for the rate period beginning July 1, 2001 remain in effect.

10-010.03B2b Calculating the Base Year Case Mix Index: For purposes of determining base rates, a base year case mix index is calculated for each hospital using all applicable claims with a first date of service that is within the base year cost reporting period. Facility specific base year case mix indices are calculated as the sum of relative weights for all base year claims, divided by the number of claims.

4. Hospital-specific base year operating costs are divided by the hospital's base year case-mix index and the number of base year Medicaid discharges, and if applicable, the hospital's indirect medical education factor.

10-010.03B4 Calculation of Peer Group Base Payment Amount: Peer group base payment amounts are calculated as a percentage of the weighted median of case mix adjusted hospital-specific base year operating costs per discharge, inflated to the midpoint of the rate year using the MBI. The peer group case-weighted median is determined and is multiplied by a percentage:

1. For metro acute care hospitals, the percentage is 85%;
2. For other urban acute care hospitals, the percentage is 100%;
3. For rural acute care hospitals, the percentage is 100%.

10-010.03B4a Consideration for Hospitals that Primarily Service Children: Effective January 1, 1997, a hospital qualifies for this group when it is located in Nebraska and is certified as meeting the criteria, as a children's hospital, for exclusion from the Medicare Prospective Payment System (PPS). The Department will make operating cost payments calculated at 120% of the peer group base payment amount for peer group 1 (Metro Acute Hospitals)

10-010.03B5 Calculation of Cost Outlier Payment Amounts: Additional payment is made for approved discharges meeting or exceeding Medicaid criteria for cost outliers for each DRG. Cost outliers may be subject to medical review.

Discharges qualify as cost outliers when the costs of the service exceed the outlier threshold. The outlier threshold is the sum of the operating cost payment amount, the indirect medical education amount, and the capital-related cost payment amount, plus $50,000. Cost of the discharge is calculated by multiplying the hospital-specific cost-to-charge ratio determined from the base year cost report times the allowed charges. Additional payment for cost outliers is 60% of the difference between the hospital's cost for the discharge and the outlier threshold for all discharges except for burn discharges, which will be paid at 67.5%.

10-010.03B6 Medical Education Costs

10-010.03B6a Calculation of Direct Medical Education Cost Payments: Hospital-specific direct medical education costs reflect the Nebraska Medical Assistance Program's average cost per discharge for approved intern and resident programs. Amounts are subject to the maximum per intern and resident amount allowed by Medicare in the base year and adjusted annually for inflation using the MBI. To determine the direct medical education payment amount for each discharge, adjusted amounts are allocated to the Medicaid program based on the percentage of Medicaid patient days to total patient days in the base-year, and are divided by the number of base year Medicaid discharges and multiplied by 75%.

NMAP will calculate a quarterly Direct Medical Education payment for services provided by NMMCP capitated plans from discharge data provided by the plan(s). Payment will be the number of discharges times the direct medical education cost payment as calculated in 471 NAC 10-010.03B6a.

10-010.03B6b Calculation of Indirect Medical Education (IME) Cost Payments: Hospitals qualify for IME payments when they receive a direct medical education payment from NMAP, and qualify for indirect medical education payments from Medicare. Recognition of indirect medical education costs incurred by hospitals are an add-on calculated by multiplying an IME factor by the sum of the operating cost payment amount and the outlier payment amount times 72.64%.

The IME factor is calculated as follows:

Effective July 1, 2001 to June 30, 2002:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1]1.60$$

Effective July 1, 2002 and thereafter:

$$[\{1+(\text{Number of Interns and Residents/Available Beds})\}^{0.405}-1]1.35$$

Base rates will be adjusted by the applicable IME factor.

10-010.03B7 Calculation of Medicaid Capital Related Costs: Medicaid capital-related per diem costs are calculated from base year Medicare cost reports as follows:

1. Routine service capital-related costs - Medicaid routine service capital-related costs are calculated by allocating total hospital routine service capital-related costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Amounts are net of swing-bed costs and observation bed capital-related costs.
2. Inpatient ancillary service capital-related costs - Medicaid inpatient ancillary service capital-related costs are calculated by multiplying an overall ancillary capital-related cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary capital-related cost-to-charge ratio is calculated by dividing the sum of the capital-related costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers.
3. Total capital-related costs are equal to the sum of Medicaid routine service capital-related costs and Medicaid inpatient ancillary service capital-related costs.
4. Building and fixtures capital-related costs are calculated by multiplying total capital-related costs times a percentage determined by dividing total hospital building and fixtures costs by total hospital capital costs.
5. The capital-related per diem cost is calculated by dividing Medicaid building and fixtures capital-related costs by the sum of base year Medicaid acute care and bassinet patient days.

Effective July 1, 2003, capital costs are calculated as 100% of the peer group weighted median cost per day. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day.

10-010.03B8 Calculation of Capital-Related Cost Payment: Capital-related cost payments for the building and fixtures portion of capital-related costs are paid on a per discharge basis. Per discharge amounts are calculated by multiplying the capital per diem cost by the statewide average length-of-stay for the DRG.

10-0103B9 (Reserved):

10-010.03B10 Facility Specific Upper Payment Limit: Facilities in Peer Groups 1,2, and 3 are subject to an upper payment limit for all cost reporting periods ending after January 1, 2001. For each cost reporting period, Medicaid payment for inpatient hospital services (with the exception of state owned/operated facilities) provided on or after July 1, 2001, shall not exceed 110% of Medicaid cost. Medicaid cost shall be the calculated sum of Medicaid allowable inpatient routine and ancillary service costs. Medicaid routine service costs are calculated by allocating total hospital routine service costs for each applicable routine service cost center based on the percentage of Medicaid patient days to total patient days. Medicaid inpatient ancillary service costs are calculated by multiplying an overall ancillary cost-to-charge ratio times the applicable Medicaid program inpatient ancillary charges. The overall ancillary cost-to-charge ratio is calculated by dividing the sum of the costs of all ancillary and outpatient service cost centers by the sum of the charges for all ancillary and outpatient service cost centers. Payments shall include all operating cost payments, capital related cost payments, direct medical education cost payments, indirect medical education cost payments, cost outlier payments, and all payments received from other sources for hospital care provided to Medicaid eligible patients. Payment under Medicaid shall constitute reimbursements under this subsection for days of service that occurred during the cost reporting period.

10-010.03B10a Reconciliation to Facility Upper Payment Limit: Facilities will be subject to a preliminary and a final reconciliation of Medicaid payments to allowable Medicaid costs. A preliminary reconciliation will be made within six months following receipt by the Department of the facility's cost report. A final reconciliation will be made within 6 months following receipt by the Department of the facility's final settled cost report.

Facilities will be notified when either the preliminary or final reconciliation indicates that the facility received Medicaid payments in excess of 110% of Medicaid costs. The Department will identify the cost reporting time period for Medicaid payments, Medicaid costs, and the amount of overpayment that is due the Department. Facilities will have 90 days to make refunds to the Department, when notified that an overpayment has occurred.

10-010.03B11 Adjustment of Rates: Effective for the rate period beginning July 1, 2003, the peer group base payment amount and the direct medical education payment amount will be inflated using the MBI. Effective September 1, 2003, the peer group base payment amount in effect for the rate period ending June 30, 2003 shall be reduced by 3.15% and remain in effect until June 30, 2004. The peer group base payment amount and the direct medical education payment amount will be inflated using the MBI for the rate period beginning July 1, 2004.

10-010.03B12 Transfers: When a patient is transferred to or from another hospital, the Department shall make a transfer payment to the transferring hospital if the initial admission is determined to be medically necessary.

For hospital inpatient services reimbursed on a prospective discharge basis, the transfer payment is calculated based on the average daily rate of the transferring hospital's payment for each day the patient remains in that hospital, up to 100 % of the full DRG payment. The average daily rate is calculated as the full DRG payment, which is the sum of the operating cost payment amount, capital-related cost payment, and if applicable, direct medical education cost payment, divided by the statewide average length-of-stay for the related DRG.

For hospitals receiving a transferred patient, payment is the full DRG payment and, if applicable, cost outlier payment.

10-010.03B13 Inpatient Admission After Outpatient Services: A patient may be admitted to the hospital as an inpatient after receiving hospital outpatient services. When a patient is admitted as an inpatient within three calendar days of the day that the hospital outpatient services were provided, all hospital outpatient services related to the principal diagnosis are considered inpatient services for billing and payment purposes. The day of the admission as an inpatient is the first day of the inpatient hospitalization.

10-010.03B14 Readmissions: NMAP adopts Medicare peer review organization (PRO) regulations to control increased admissions or reduced services. All NMAP patients readmitted as an inpatient within 31 days will be reviewed by the Department or its designee. Payment may be denied if either admissions or discharges are performed without medical justification as determined medical review.

(2) Disproportionate Share Payment for Hospitals that Primarily Serve Children (Pool 2): For FFY03 and succeeding years, the Department will make a disproportionate share payment to the hospital that both primarily serves children, and has the greatest number of Medicaid days, for an amount not to exceed $2,000,000 annually plus the federally allowed inflation. A hospital eligible for payment under this pool will not be eligible for payment under any other pool. If payment to the hospital exceeds the disproportionate share payment limit, as established under 1923 (f) of the Social Security Act, the payment will be reduced.

(3) Disproportionate Share Payment for State Owned Institutions for Mental Disease (IMD) Hospitals and for eligible hospitals in Peer Group 4 (Pool 3): For FFY03 and succeeding years, the Department will determine a disproportionate share payment for eligible hospitals using the data and methods described below.

(a) Total funding to the State Owned Institutions for Mental Disease (IMD) Hospitals and hospitals in Peer Group 4 Pool will not exceed $1,811,337 annually.

(b) Payments will be calculated as follows:

[1] The DSH payment for each hospital for this pool will be the cost of uncompensated care.

[2] Eligible hospitals must certify in writing to the Nebraska Medical Assistance Program its charges for uncompensated care for the hospital's fiscal year ending in the calendar year preceding the federal fiscal year for which the determination is applied. Charges for uncompensated care will be converted to cost using the hospitals cost to charge ratio.

[3] Payment to each hospital will be equal to the cost of its uncompensated care.

[4] If the total of all disproportionate share payment amounts for State Owned Institutions for Mental Disease (IMD) Hospitals and Peer Group 4 Hospitals exceeds in any given federal fiscal year, the federally determined disproportionate share limit for Nebraska, the DSH payments will be reduced prorata.

[5] A hospital eligible for payment under this pool will not be eligible for payment under any other pool.

(4) Non-Profit Acute Care Teaching Hospital affiliated with a State-Owned University Medical College (Pool 4): For FFY03 and succeeding years, the Department will create a disproportionate share pool for the non-profit acute care teaching hospital, subsequently referred to as the state teaching hospital, that has an affiliation with the University Medical college owned by the State of Nebraska.
   (a) Total funding to this pool will be the remaining balance of the total (federal and state) DSH funding plus the federally allowed inflation minus the funding for Pool 1, Pool 2, and Pool 3.
   (b) The DSH payment to Pool 4 will be the difference of the total (federal and state) DSH funding minus the funding for Pool 1, Pool 2, and Pool 3.
   (c) If the payment to the hospital exceeds the disproportionate share payment limit, as established under 1923(f) of the Social Security Act, the payment will be reduced.

b. Limitations on disproportionate share payments:
   (1) No payments made under this section will exceed any applicable limitations upon such payments established by Section 1923 (g)(1)(A) of the Social Security Act.
   (2) Disproportionate Share payments to all qualified hospitals for a year will not exceed the State disproportionate share hospital payment limit, as established under 1923 (f) of the Social Security Act.

10-010.03J Out-of-State Hospital Rates: The Department pays out-of-state hospitals for hospital inpatient services at the peer group rate for a like peer group of Nebraska hospitals. The peer groups are -

1. Metro Acute Care Hospitals: Hospitals located in a Metropolitan Statistical Area (MSAs) as designated by Medicare;
3. Rural Acute Care Hospitals: All other acute care hospitals;
4. Psychiatric Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as psychiatric hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.
5. Rehabilitation Hospitals and Distinct Part Units in Acute Care Hospitals: Hospitals that are licensed as rehabilitation hospitals by the licensing agency of the state in which the hospital is located and distinct parts as defined in 471 NAC 10-010.03A.

Operating cost payment amounts are calculated based on the appropriate peer group base payment amount. Capital-related cost payments are made based on the peer group weighted median capital per diem rate. Effective September 1, 2003, capital costs will be calculated as 96.85% of the peer group weighted median cost per day. The cost-to-charge ratio is the peer group average.

Payments for psychiatric and rehabilitation services provided by out-of-state hospitals are made on a prospective per diem. Hospitals are paid based on the peer group per diem rate for the appropriate type of service. Operating cost payment amounts are calculated based on the appropriate peer group per diem rate. Capital-related cost payments are made based on the peer group weighted median capital per diem rate.

The Department may allow payments to out-of-state hospitals for direct or indirect medical education costs at a negotiated per discharge rate.

10-010.03J1 Exception: The Administrator of the Medicaid Division may enter into an agreement with an out-of-state hospital for a rate that exceeds the rate or fee established in 471 NAC 10-010.03J only when the Medical Director of the Department has determined that -

1. The client requires specialized services that are not available in Nebraska; and
2. No other source of the specialized services can be found to provide the services at the rate established in 471 NAC 10-010.03J.

10-010.03K Out-of-Plan Services: When enrollees in the Nebraska Health Connection are provided hospital inpatient services by facilities not under contract with the Department's prepaid health care organizations, the Department contracted prepaid health care organizations are authorized, but are not required, to pay providers of hospital inpatient services who care for individuals enrolled in the Nebraska Health Connection at rates the Department would otherwise reimburse providers under 471 NAC 10-010.03ff.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment to Hospital-Affiliated Ambulatory Surgical Centers: The Department pays for services provided in an HAASC according to Payment for Outpatient Hospital and Emergency Room Services, unless the HAASC is a Medicare-participating ambulatory surgical center (ASC). If the HAASC is a Medicare-participating ASC, payment is made according to Medicare methods.

Approval of Payment for Emergency Room Services: At least one of the following conditions must be met before the Department approves payment for use of an emergency room:

1. The patient is evaluated or treated for a medical emergency, accident, or injury (see definition of medical emergency in 471 NAC 10-001.02);
2. The patient's evaluation or treatment in the emergency room results in an approved inpatient hospital admission (the emergency room charges must be displayed on the inpatient claim as ancillary charges and included in the inpatient per diem); or
3. The patient is referred by a physician such as for allergy shots or when traveling (a written referral by the physician must be attached to the claim);

The facility should review emergency room services and determine whether services provided in the emergency room constitute an emergency and bill accordingly.
When the facility or the Department determine services are non-emergent, the room fee for non-emergent services provided in an emergency room will be disallowed to 50 percent of the applicable ratio of cost-to-charges. All other Medicaid allowable charges incurred in this type of visit will be paid at 82.45% of the ratio of cost-to-charges.

Diagnostic and Therapeutic Services: The payment rate for diagnostic and therapeutic services includes payment for services required to provide the service. Extra charges, such as stat fees, call-back fees, specimen handling fees, etc., are considered administrative expenses and are included in the payment rate.

Payment to a New Hospital for Outpatient Services: See the definition of a new operational facility in 471 NAC 10-010.03A. Payment to a new hospital (a new operational facility) will be made at 82.45% of the statewide average ratio of cost to charges for Nebraska hospitals as of July 1 of that year as determined by the Department. This payment is retrospective for the first reporting period for the facility. This ratio will be used until the Department receives the hospital's initial cost report. The Department shall cost-settle claims for Medicaid-covered services which are paid by the Department using 82.45% of the statewide average ratio of cost to charges. The cost settlement will be the lower of cost or charges as reflected on the hospital's cost report (i.e., the Department's payment must not exceed the upper limit of the provider's charges for services).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Payment for Outpatient Hospital and Emergency Room Services: For services provided on or after September 1, 2003, the Department pays for outpatient hospital and emergency services with a rate which is the product of -

1. Eighty-two point forty five (82.45) percent of the cost-to-charges ratio from the hospital's latest Medicare cost report (Form HCFA-2552-89, Pub. 15-II, Worksheet C); multiplied by
2. The hospital's submitted charges on Form HCFA-1450 (UB-92).

The effective date of the cost-to-charges percentage is the first day of the month following the Department's receipt of the cost report.

Providers shall bill outpatient hospital and emergency room services on Form HCFA-1450 (UB-92) in a summary bill format. Providers shall not exceed their usual and customary charges to non-Medicaid patients when billing the Department.

Exception: All outpatient clinical laboratory services must be itemized and identified with the appropriate HCPCS procedure codes. The Department pays for clinical laboratory services on the fee schedule determined by HCFA.

Payment for Outpatient Hospital and Emergency Room Services Provided by Critical Access Hospitals: Effective for cost reporting periods beginning after July 1, 1999, payment for outpatient services of a CAH is the reasonable cost of providing the services, as determined under applicable Medicare principles of reimbursement, except that the following principles do not apply: the lesser of costs or charges (LCC) rule and the reasonable compensation equivalent (RCE) limits for physician services to providers. NMAP will adjust interim payments to reflect elimination of any fee schedule methods for specific services, such as laboratory or radiology services, that were previously paid for under those methods. Payment for these and other outpatient services will be made in accordance with reasonable cost principles. Professional services must be billed by the physician or practitioner using the appropriate physician/practitioner provider number, not the facility's provider number. To avoid any interruption of payment, NMAP will retain and continue to bill under existing provider numbers until new CAH numbers are assigned.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

Upon the Department's receipt of the hospital's initial Medicare cost report, the Department shall no longer consider the hospital to be a "new hospital" for payment of outpatient services. The Department shall determine the ratio of cost to charges from the initial cost report and shall use that ratio to prospectively pay for outpatient services. (For a complete description of payment for outpatient services, see 471 NAC 10-010.06 ff.)

Payment to An Out-of-State Hospital for Outpatient Services: Payment to an out-of-state hospital for outpatient services will be made based on the statewide average ratio of cost to charges times 82.45% for all Nebraska hospitals for that fiscal year as of July 1 of that year.

Payment for Telehealth Services: Payment for telehealth services is set at the Medicaid rate for the comparable in-person service.

Payment for Telehealth Transmission Costs: Payment for telehealth transmission costs is set at the lower of: (1) the provider's submitted charge; or (2) the maximum allowable amount.

The Department reimburses transmission costs for the line charges when directly related to a covered telehealth service. The transmission must be in compliance with the quality standards for real time, two-way interactive audio-visual transmission as set forth in state regulations, as amended.
